	FO	R BHF	USE		

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2005 STATE OF ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2005)

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility II	D Number: 0038	3349		II. CERTI	FICATION BY AUTHORIZED FACILITY OFFICER
	Heritage Manor-Blooming 0 East Walnut Number CLean	Bloomington City	61701 Zip Code	State of and certain	re examined the contents of the accompanying report to the fillinois, for the period from 01/01/05 to 12/31/05 rtify to the best of my knowledge and belief that the said contents e, accurate and complete statements in accordance with ble instructions. Declaration of preparer (other than provider)
Telephone Num HFS ID Number Date of Initial L	· · · · · · · · · · · · · · · · · · ·	Fax # ()		is base Inter	d on all information of which preparer has any knowledge. Intional misrepresentation or falsification of any information cost report may be punishable by fine and/or imprisonment. [(Signed)
Ch	hip: ITARY,NON-PROFIT naritable Corp. rust	xx PROPRIETARY Individual Partnership	GOVERNMENTAL State County	Administrator of Provider	(Type or Print Name) Craig L. Ater (Title) Senior V.P. & CFO (Signed)
IRS Exemption	Code	Corporation xx "Sub-S" Corp. Limited Liability Co. Trust Other	Other	Paid Preparer	(Date) (Print Name and Title) (Firm Name & Address) (Telephone)
In the event ther Name: <u>Craig Ate</u>	re are further questions about t er)823-7135		ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630

STATE OF ILLINOIS Page 2

Faci	lity Name & ID Numb	oer Heritage Mai	nor-Bloomington				# 0038349	Report Period Beginning:	01/01/05 Er	nding:	12/31/05			
	III. STATISTICA	L DATA			D. How many bed	-hold days during this year were	paid by the Departm	ient?						
	A. Licensure/o	certification level(s) of	f care; enter number	of beds/bed days,		0	(Do not include bed-hold days	in Section B.)						
	(must agree	with license). Date of	change in licensed b	eds		_								
				_		_	E. List all services	provided by your facility for no	n-patients.					
	1	2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)							
							none							
	Beds at				Licensed									
	Beginning of	Licensu	re	Beds at End of	Bed Days During		F. Does the facility	y maintain a daily midnight cens	us? yes					
	Report Period	Level of	Care	Report Period	Report Period		·	,						
	_			_			G. Do pages 3 & 4	include expenses for services or						
1	111	Skilled (SNI	F)	111	40,515	1		t directly related to patient care:						
2			atric (SNF/PED)		.,,	2	YES	NO XX						
3		Intermediat	e (ICF)			3	·							
4		Intermediat	e/DD			4	H. Does the BALA	ANCE SHEET (page 17) reflect a	ny non-care assets?					
5		Sheltered C	are (SC)			5	YES	NO xx	•					
6		ICF/DD 16	or Less											
							I. On what date di	care at this location?						
7	111	TOTALS		111	40,515	7	Date started	1963						
							<u></u>	purchased or leased after Janua						
	B. Census-For	r the entire report per					YES	Date	NO xx					
	1	2	3	4	5									
	Level of Care		by Level of Care and	d Primary Source of	Payment	4 1		y certified for Medicare during t						
		Medicaid					YES		f YES, enter number					
		Recipient	Private Pay	Other	Total		of beds certified	l and day	s of care provided		5,117			
	SNF	19,125	11,239	5,117	35,481	8								
	SNF/PED			0		9	Medicare Interme	ediary Mutual of Omaha						
	ICF					10								
	ICF/DD					11	IV. ACCOUNTIN							
	SC	0	0	0		12		MODIFIED						
13	DD 16 OR LESS					13	ACCRUAL X	CASH*	CASH*	·				
14	TOTALS	19,125	11,239	5,117	35,481	14	Is your fiscal yea	r identical to your tax year?	YES N	NO				
	C Donort Oc	ecupancy. (Column 5,	ling 14 divided by to	tal liganged			Tax Year:	Fiscal Year:						
		n line 7, column 4.)	87.57%	tai neenseu				er than governmental must repo	rt on the accrual basis	<u>s.</u>				
	Sea days of	,,	07.67.70	-			in inclines our	or commenced mast repor						

Facility Name & ID Number Heritage Manor-Bloomington 0038349 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05 V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar) FOR OHF USE ONLY Costs Per General Ledger Reclassified Adjust-Reclass-Adjusted **Operating Expenses** Salary/Wage Supplies Other Total ification **Total** ments Total A. General Services 2 3 4 5 6 7 8 9 10 216,875 24,905 241,780 241,780 4,899 246,679 Dietary 1 Food Purchase 175,860 175,860 175,860 175,860 2 Housekeeping 93,573 93,573 93,578 3 76,776 16,797 14,599 79,923 79,923 79,923 Laundry 65,324 4 5 Heat and Other Utilities 121,097 121,097 121,097 1,546 122,643 5 Maintenance 103,236 41,339 198,147 198,147 12,958 211,105 53,572 6 Other (specify):* 7 **TOTAL General Services** 462,211 285,733 162,436 910,380 910,380 19,408 929,788 8 B. Health Care and Programs Medical Director 12,000 12,000 12,000 12,000 9 10 Nursing and Medical Records 1,591,794 145,257 125,045 1,862,096 1,862,096 1,862,096 10 972,772 **10a** Therapy 353,217 619,555 (507,570)465,202 114,184 579,386 10a 11 Activities 52,473 2,259 54,732 54,732 54,732 11 49,443 49,443 Social Services 46,862 **72** 2,509 49,443 12 13 CNA Training 10,744 (2.550)8,194 8.194 1,741 9,935 13 14 Program Transportation 14 15 Other (specify):* 15 16 TOTAL Health Care and Programs 1,701,873 498,255 759,109 2,959,237 (507,570)2,451,667 115,925 2,567,592 16 C. General Administration 59,000 59,000 75,117 134,117 17 Administrative 59,000 17 18 Directors Fees 5,576 5,576 18 Professional Services 343,163 343,163 343,163 (327,669)15,494 19 20 Dues, Fees, Subscriptions & Promotions 107,192 30,326 107,192 (60,773)46,419 (16,093)20 21 Clerical & General Office Expenses 152,940 152,940 155,048 307,988 21 122,705 15,087 15,148 452,948 40,355 493,303 22 **Employee Benefits & Payroll Taxes** 452,948 452,948 1,307 1,999 Inservice Training & Education 692 692 692 23 24 Travel and Seminar 4,337 4,337 4,337 (2,338)1,999 24 25 Other Admin. Staff Transportation 25 26 Insurance-Prop.Liab.Malpractice 78,148 78,148 1,979 80,127 26 78,148 27 Other (specify):* 51,096 51,096 51,096 (51,000)96 27 28 TOTAL General Administration 1,052,724 (60,773)1,188,743 1,071,025 181,705 15,087 1,249,516 (117,718)28 **TOTAL Operating Expense** 2,345,789 799,075 (568,343)4,550,790 29 1,974,269 5,119,133 17,615 4,568,405 (sum of lines 8, 16 & 28)

STATE OF ILLINOIS

Page 3

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Page 4 12/31/05 #0038349 **Report Period Beginning: Facility Name & ID Number** Heritage Manor-Bloomington 01/01/05 Ending:

V. COST CENTER EXPENSES (continued)

			Cost Per General Ledger Rec				Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	T
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			149,305	149,305		149,305	13,149	162,454			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			125,414	125,414		125,414	22,734	148,148			32
33	Real Estate Taxes			76,294	76,294		76,294		76,294			33
34	Rent-Facility & Grounds							671	671			34
35	Rent-Equipment & Vehicles			3,639	3,639		3,639	1,010	4,649			35
36	Other (specify):*											36
37	TOTAL Ownership			354,652	354,652		354,652	37,564	392,216			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					507,570	507,570		507,570			39
40	Barber and Beauty Shops			15,582	15,582		15,582		15,582			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					60,773	60,773		60,773			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			15,582	15,582	568,343	583,925		583,925			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,345,789	799,075	2,344,503	5,489,367		5,489,367	55,179	5,544,546			45

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Heritage Manor-Bloomington

Report Period Beginning: # 0038349

01/01/05

Ending:

55,179

Page 5

2

4

37

12/31/05

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. VI. ADJUSTMENT DETAIL In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	III Column	1 2 Delow	1	nie on w	nich the particul	T COS
			•	Refer-	OHF USE	
	NON-ALLOWABLE EXPENSES		Amount	ence	ONLY	
1	Day Care	\$			\$	1
2	Other Care for Outpatients					2
3	Governmental Sponsored Special Programs					3
4	Non-Patient Meals					4
5	Telephone, TV & Radio in Resident Rooms		(694)	35		5
6	Rented Facility Space		(6,120)	34		6
7	Sale of Supplies to Non-Patients					7
8	Laundry for Non-Patients					8
9	Non-Straightline Depreciation			30		9
10	Interest and Other Investment Income		(158)	32		10
11	Discounts, Allowances, Rebates & Refunds					11
12	Non-Working Officer's or Owner's Salary					12
13	Sales Tax			2		13
14	Non-Care Related Interest			32		14
15	Non-Care Related Owner's Transactions			33		15
16	Personal Expenses (Including Transportation)			24		16
17	Non-Care Related Fees		(528)	20		17
18	Fines and Penalties					18
19	Entertainment		(12,673)	24		19
20	Contributions			27		20
21	Owner or Key-Man Insurance					21
22	Special Legal Fees & Legal Retainers		(4,935)	19		22
23	Malpractice Insurance for Individuals		· .			23
24	Bad Debt		(51,000)	27		24
25	Fund Raising, Advertising and Promotional		(20,280)	20		25
	Income Taxes and Illinois Personal					1
26	Property Replacement Tax		_			26
27						27
28						28
29	Other-Attach Schedule			23		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$	(96,388)		\$	30

	OHF USE ONLY				
48	49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	151,567		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 151,567		36

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

(sum of SUBTOTALS

37 TOTAL ADJUSTMENTS (A) and (B)

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.) 1 2

		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
	Barber and Beauty Shops					41
	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS

Page 5A

Heritage Manor-Bloomington

| ID# | 0038349 | Report Period Beginning: 01/01/05 | Ending: 12/31/05

Sch. V Line

1 \$ 1 2 3 3 4 5 (694) 35 6 (6,120) 34 7 8 9 0 30 9 10 32 10 11 11 11 12 12 12 13 0 2 13 14 32 14 15 0 33 15 16 24 16 17 (528) 20 17 18 19 24 19 20 0 27 20 21 (4,935) 19 22 23 (4,935) 19 22 23 (20,280) 20 25 25 (20,280) 20 25 26 27 26
3 (694) 35 5 6 (6,120) 34 6 7 (6,120) 34 6 7 (6,120) 34 6 7 (6,120) 34 6 7 (6,120) 34 6 7 (6,120) 30 9 8 (7 8 8 9 0 30 9 10 32 10 11 11 11 11 12 12 12 12 12 13 14 12 12 13 14 14 32 14 14 32 14 14 14 32 14 15 15 16 24 16 16 17 18 19 22 22 24 19 22 23 24 19 22 23 24 19 24 19 24 19 24 19 24
4 (694) 35 5 6 (6,120) 34 6 7 8 8 8 8 9 0 30 9 10 32 10 11 11 11 12 12 12 13 0 2 13 14 32 14 15 0 33 15 16 24 16 17 (528) 20 17 18 18 19 24 19 20 0 27 20 21 21 21 22 (4,935) 19 22 23 24 (51,000) 27 24 25 (20,280) 20 25 26
5 (694) 35 5 6 (6,120) 34 6 7 7 7 8 9 0 30 9 10 32 10 11 11 11 12 0 2 13 14 32 14 15 0 33 15 16 24 16 17 (528) 20 17 18 18 19 24 19 20 0 27 20 21 21 21 22 (4,935) 19 22 23 24 (51,000) 27 24 25 (20,280) 20 20 25 26
6 (6,120) 34 6 7 8 7 8 9 0 30 9 10 32 10 11 11 11 12 12 12 13 0 2 13 14 32 14 15 0 33 15 16 24 16 17 (528) 20 17 18 18 19 24 19 20 0 27 20 21 22 (4,935) 19 22 23 24 (51,000) 27 24 25 (20,280) 20 25 26 26
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11 12 13 0 2 13 14 32 13 15 0 33 15 16 24 16 17 (528) 20 17 18 18 18 19 24 19 20 0 27 20 21 21 21 22 (4,935) 19 22 23 23 24 (51,000) 27 24 25 (20,280) 20 25 26 26
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13 0 2 13 14 32 14 15 0 33 15 16 24 16 17 (528) 20 17 18 18 18 19 24 19 20 0 27 20 21 21 21 22 (4,935) 19 22 23 23 24 (51,000) 27 24 25 (20,280) 20 25 26 26
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15 0 33 15 16 24 16 17 (528) 20 17 18 18 24 19 20 0 27 20 21 21 21 21 22 (4,935) 19 22 23 23 23 24 (51,000) 27 24 25 (20,280) 20 25 26 26
16 24 16 17 (528) 20 17 18 18 18 18 20 0 27 20 21 21 21 21 22 (4,935) 19 22 23 23 23 23 24 (51,000) 27 24 25 (20,280) 20 25 26 26
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49 Total (83,557) 49

Summary A Facility Name & ID Number Heritage Manor-Bloomington
SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I # 0038349 Report Period Beginning: 01/01/05 **Ending:** 12/31/05

	SUMMARY OF PAGES 5, 5A, 6, 6A	1, 0D, 0C, 0D,	oe, or, og, o	n AND 01	I	1	1						CENT OF A DAY
		D. CEG	D. CE	D. CE	D. CE	D. CE	D. CE	D. CE	D. CE	D. CE	D. CE	D. CE	SUMMARY
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS
-	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6Н	61	(to Sch V, col.7)
1	Dietary	0	0	4,899	0	0	0	0	0	0	0	0	4,899 1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0 2
3	Housekeeping	0	0	5	0	0	0	0	0	0	0	0	5 3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0 4
5	Heat and Other Utilities	0	0	1,546	0	0	0	0	0	0	0	0	1,546 5
6	Maintenance	0	0	12,958	0	0	0	0	0	0	0	0	12,958 6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 7
8	TOTAL General Services	0	0	19,408	0	0	0	0	0	0	0	0	19,408 8
	B. Health Care and Programs												
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0 9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0 10
10a	Therapy	0	114,184	0	0	0	0	0	0	0	0	0	114,184 10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0 11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0 12
13	CNA Training	0	0	1,741	0	0	0	0	0	0	0	0	1,741 13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0 14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 15
16	TOTAL Health Care and Programs	0	114,184	1,741	0	0	0	0	0	0	0	0	115,925 16
	C. General Administration												
17	Administrative	0	0	75,117	0	0	0	0	0	0	0	0	75,117 17
18	Directors Fees	0	0	5,576	0	0	0	0	0	0	0	0	5,576 18
19	Professional Services	(4,935)	(338,228)	15,494	0	0	0	0	0	0	0	0	(327,669) 19
20	Fees, Subscriptions & Promotions	(20,808)	0	4,715	0	0	0	0	0	0	0	0	(16,093) 20
21	Clerical & General Office Expenses	0	0	155,048	0	0	0	0	0	0	0	0	155,048 21
22	Employee Benefits & Payroll Taxes	0	0	40,355	0	0	0	0	0	0	0	0	40,355 22
23	Inservice Training & Education	0	0	1,307	0	0	0	0	0	0	0	0	1,307 23
24	Travel and Seminar	(12,673)	0	10,335	0	0	0	0	0	0	0	0	(2,338) 24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0 25
26	Insurance-Prop.Liab.Malpractice	0	0	1,979	0	0	0	0	0	0	0	0	1,979 26
27	Other (specify):*	(51,000)	0	0	0	0	0	0	0	0	0	0	(51,000) 27
28	TOTAL General Administration	(89,416)	(338,228)	309,926	0	0	0	0	0	0	0	0	(117,718) 28
	TOTAL Operating Expense												
29	(sum of lines 8,16 & 28)	(89,416)	(224,044)	331,075	0	0	0	0	0	0	0	0	17,615 29

STATE OF ILLINOIS Summary B

Facility Name & ID Number Heritage Manor-Bloomington # 0038349 Report Period Beginning: 01/01/05 Ending: 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 G	6H	6I	(to Sch V, col	.7)
30	Depreciation	0	0	0	13,149	0	0	0	0	0	0	0	13,149	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(158)	0	0	22,892	0	0	0	0	0	0	0	22,734	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(6,120)	0	0	6,791	0	0	0	0	0	0	0	671	34
35	Rent-Equipment & Vehicles	(694)	0	0	1,704	0	0	0	0	0	0	0	1,010	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(6,972)	0	0	44,536	0	0	0	0	0	0	0	37,564	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(96,388)	(224,044)	331,075	44,536	0	0	0	0	0	0	0	55,179	45

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VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

the below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional solication in necessary.										
1		2			3					
OWNERS	S	RELATED NURSING HOMES			OTHER REL	ATED BUSINESS	S ENTITIE	ES		
Name Ownership %		Name	ame City N		Name	City		Type of Business		
See Attached										

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, xx YES management fees, purchase of supplies, and so forth. NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
			-		-	Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
					_	Ownership	Organization	Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V	10a	Adjustment for Related Organiza	tion					2
3	V								3
4	V	19	Adjustment for Related Organiza	tion 338,228	Heritage Enterprises, Inc.	100.00%		(338,228)	4
5	V								5
6	V	10a	Adjustment for Related Organiza	tion 350,840	GreenTree Pharmacy	100.00%	465,024	114,184	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 689,068			\$ 465,024	\$ * (224,044)	14

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS				I	Page 6A
#	0038349	Report Period Reginning	01/01/05	Ending	12/31/05

VII.	RELA	TED	PA	RTIE	S ((continued))
------	------	-----	----	------	-----	-------------	---

Facility Name & ID Number

В.	Are any costs included in this report which are a result of transactions with	h relat	ted organizatio	ons? I	This includes rent,
	management fees, purchase of supplies, and so forth.		YES		NO

Heritage Manor-Bloomington

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sche	dule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
					<u> </u>	Ownership	Organization	Costs (7 minus 4)	
15	V	1	Dietary	\$	Heritage Enterprises, Inc.	100.00%			15
16	V	2	Food Purchase				0	Í	16
17	V	3	Housekeeping				5	5	17
18	V	4	Laundry				0		18
19	V	5	Heat & Other Utilities				1,546	1,546	
20	${f V}$	6	Maintenance				12,958	12,958	20
21	V	7	Other				0		21
22	V	9	Medical Director				0		22
23	\mathbf{V}	10	Nursing & Medical Records				0		23
24	V	11	Activities				0		24
25	V	12	Social Service				0		25
26	V	13	Nurse Aide Training				1,741	1,741	26
27	V	14	Program Transportation				0		27
28	V		Other				0		28
29	V	17	Administrative				75,117	75,117	29
30	V	18	Directors Fees				5,576	5,576	
31	V	19	Professional Services				15,494	15,494	
32	V	20	Fees, Subscription, Promotions				4,715	4,715	
33	V	21	Clerical & General Office Expenses				155,048	155,048	
34	V	22	Employee Benefits & Payroll Taxes		<u> processor de la companya del companya de la companya del companya de la company</u>		40,355	40,355	
35	V	23	Inservice Training & Education				1,307	1,307	
36	V	24	Travel and Seminar		<u>, and the state of the state o</u>		10,335	10,335	
37	V		Other Admin. Staff Transportation				0		37
38	V	26	Insurance-Prop.Liab.Malpract				1,979	1,979	38
39	Total			\$			\$ 331,075	* 331,075	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

	ST	ATE OF ILLINOIS				P	age 6B	
Facility Name & ID Number	Heritage Manor-Bloomington	#	0038349	Report Period Beginning:	01/01/05	Ending:	12/31/05	
VII. RELATED PARTIES (continu B. Are any costs included in this management fees, purchase of	report which are a result of transactions with related organizations	? This includes rent,						

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sche	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	i
						Ownership	Organization	Costs (7 minus 4)	
15	V	27	Other	\$	Heritage Enterprises, Inc.	100.00%		\$ 0	15
16	V		Depreciation					13,149	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					22,892	18
19	V		Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					6,791	20
21	V	35	Rent-Equipment & Vehicles					1,704	21
22	V	36	Other					0	22
23	V	38	Medically Nec Transportation					0	23
24	V	39	Ancillary Service Centers					0	24
25	V	40	Barber and Beauty Shops					0	25
26	V	41	Coffee and Gift Shops					0	26
27	V	42	Other					0	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V		_						37
38	V								38
39	Total			\$			\$ 0	\$ * 44,536	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

Page 7

Facility Name & ID Number Heritage Manor-Bloomington # 0038349 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hou	rs Per Work				l
					Compensation	Week Devo	ted to this	Compensati	on Included	Schedule V.	l
					Received	Facility and	% of Total	in Costs	for this	Line &	l
				Ownership	From Other	Work	Week	Reportin	g Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	1
1	Susie Jefferson	Director	Management	15.86				Salary/BOD	\$ 16,950	Ln 17&18	1
2	Estate of Tom Jefferson			16.21				Salary/BOD	0	Ln 17&18	2
3	Craig Hart	Chairman	Management	31.95				Salary/BOD	19,008	Ln 17&18	3
4	Cheryl Lowney	Executive Vice Pres	i Management	0.49		40	100.00	Salary/BOD	11,318	Ln 17&18	4
5	Steve Wannemacher	President	Management	0.42		40	100.00	Salary/BOD	14,750	Ln 17&18	5
6	Connie Hoselton	Sr Vice President	Management	0.27		40	100.00	Salary	7,278	Ln 17&18	6
7	Craig Ater	Sr Vice President	Management	0.34		40	100.00	Salary	8,157	Ln 17&18	7
8	Ben Hart	Vice President	Management	3.20		40	100.00	Salary	3,232	Ln 17&18	8
9]								9
10											10
11											11
12											12
13								TOTAL	\$ 80,693		13

^{*} If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

^{**} This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).

FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,

ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Page 8 0038349 Report Period Beginning: **Facility Name & ID Number Heritage Manor-Bloomington** 01/01/05 **Ending:** 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which	were derived from	allocations	of central o	office
or parent organization costs? (See instructions.)	YES	XX	NO	

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization **Heritage Enterprises Street Address** 115 W. Jefferson City / State / Zip Code Phone Number Bloomington,II Fax Number

	1	2	3	4	5	6	7	8	9	\Box
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	1	Dietary	Beds	2,612	25	\$ 115,289	\$ 115,276	111	\$ 4,899	1
2	2	Food Purchase	Beds	2,612	25	7	0	111	0	2
3	3	Housekeeping	Beds	2,612	25	124	0	111	5	3
4			Beds	2,612	25	0	0	111	0	4
5	5	Heat & Other Utilities	Beds	2,612	25	36,387	0	111	1,546	5
6	6	Maintenance	Beds	2,612	25	304,933	79,110	111	12,958	6
7			Beds	2,612	25	0	0	111	0	7
8	9	Medical Director	Beds	2,612	25	0	0	111	0	8
9	10		Beds	2,612	25	0	0	111	0	9
10	11	Activities	Beds	2,612	25	0	0	111	0	10
11		Social Service	Beds	2,612	25	0	0	111	0	11
12			Beds	2,612	25	40,976	40,976	111	1,741	12
13	14	<u> </u>	Beds	2,612	25	0	0	111	0	13
14	15		Beds	2,612	25	0	0	111	0	14
15	17	Administrative	Beds	2,612	25	1,767,611	1,767,611	111	75,117	15
16		Directors Fees	Beds	2,612	25	131,223	0	111	5,576	16
17			Beds	2,612	25	364,592	0	111	15,494	17
18			Beds	2,612	25	110,958	0	111	4,715	18
19		Clerical & General Office Expense		2,612	25	3,648,522	3,309,912	111	155,048	19
20		Employee Benefits & Payroll Taxe	Beds	2,612	25	949,625	0	111	40,355	20
21		8	Beds	2,612	25	30,747	0	111	1,307	21
22			Beds	2,612	25	243,204	0	111	10,335	22
23		Other Admin. Staff Transportatio	Beds	2,612	25	0	0	111	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,612	25	46,560	0	111	1,979	24
25	TOTALS					\$ 7,790,758	\$ 5,312,885		\$ 331,075	25

		TT	TIN	TA
STA	 ()H	11.		N()

OIS Page 8A Facility Name & ID Number **Heritage Manor-Bloomington** # 0038349 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.)	City / State / Zip Code	
	Phone Number	()
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	()

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	\Box
	Schedule V	-	Unit of Allocation	•	Number of	Total Indirect	Amount of Salary	Ü		
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	27	Other	Beds	2,612	25	\$	\$	111		1
2	30	Depreciation	Beds	2,612	25	309,426	Ψ	111	13,149	2
3	31		Beds	2,612	25	,		111	-,	3
4	32	Interest	Beds	2,612	25	538,695		111	22,892	4
5	33	Real Estate Taxes	Beds	2,612	25	,		111	•	5
6	34	Rent-Facility & Grounds	Beds	2,612	25	159,809		111	6,791	6
7	35		Beds	2,612	25	40,093		111	1,704	7
8	36		Beds	2,612	25			111		8
9	38		Beds	2,612	25			111		9
10	39	Ancillary Service Centers	Beds	2,612	25			111		10
11	40		Beds	2,612	25			111		11
12	41	Coffee and Gift Shops	Beds	2,612	25			111		12
13	42	Other	Beds	2,612	25			111		13
14								111		14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,048,023	\$		\$ 44,536	25

STATE OF ILLINOIS											
Facil	ity Name & ID Number	Heritage Mai	nor-Bloomington	#	0038349	Report Period	Beginning:	01/01/05	Ending:	12/31/05	
	IX. INTEREST EXPENSE AN A. Interest: (Complete deta	· -	ATE TAX EXPENSE vided for each loan - attach a sep	parate schedule if	necessary.)	ı					
	1	2	3	4	5	6	7	8	9	10	
		D. I. c. Mark		Monthly	D			Maturity	Interest	Reporting Period	

	<u> </u>			3			U	<u></u>			10	
	Name of Lender	Relate	ed** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amoi Original	ınt of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A Di	IES	но		Requireu	Note	Original	Datance		(4 Digits)	Expense	_
	A. Directly Facility Related											
	Long-Term											
1	LsSalle National Bank			Mortgage	4640 plus Int	01/15/99	\$	\$ 1,794,557	01/15/06	variable	\$ 101,184	
2	LsSalle National Bank		XX	Mortgage							5,534	2
3												3
4												4
5												5
	Working Capital											
6	LsSalle National Bank		XX	Working Capital							18,696	6
	LsSalle National Bank		XX	5 1							ŕ	7
8												8
9	TOTAL Facility Related						\$	\$ 1,794,557			\$ 125,414	
	B. Non-Facility Related*					_			•			
10	Interest Income					I			I		(158)) 10
11	Allocated Corporate										22,892	
12												12
13												13
												+==
14	TOTAL Non-Facility Related						\$	\$			\$ 22,734	14
15	TOTALS (line 9+line14)						\$	\$ 1,794,557			\$ 148,148	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.	\$	Line #
--	----	--------

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

STATE OF ILLINOIS Page 10

Facility Name & ID Number Heritage Manor-Bloomington # 0038349 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

	I was a second or a case of a case of the	4 UDC Tovil The seed	atata tau atatamant and			
	Important , please see the next workshee bill must accompany the cost report.	et, RE_Tax . The real of	estate tax statement and			
1. Real Estate Tax accrual used on 2004 report.	bill must accompany the cost report.			\$	72,337	1
2. Real Estate Taxes paid during the year: (Indica	ate the tax year to which this payment applies. If payment co	overs more than one year, de	tail below.)	\$	72,503	2
3. Under or (over) accrual (line 2 minus line 1).				\$	166	5 3
4. Real Estate Tax accrual used for 2005 report.	(Detail and explain your calculation of this accrual on the lin	nes below.)		\$	76,128	4
	hich has NOT been included in professional fees or other ge copies of invoices to support the cost and a c			¢		5
(Describe appear cost below. Attach	copies of invoices to support the cost and a c	opy of the appearmet	with the county.	Φ		
6. Subtract a refund of real estate taxes. You mu	st offset the full amount of any direct appeal costs					
the state of the s						
classified as a real estate tax cost plus one-half		roal ostato tay appoal	hoard's docision \	¢		
classified as a real estate tax cost plus one-half TOTAL REFUND \$ For		real estate tax appeal	board's decision.)	\$,
TOTAL REFUND \$ For		real estate tax appeal	board's decision.)	\$ \$	76,294	
7. Real Estate Tax expense reported on Schedule	Tax Year. (Attach a copy of the	real estate tax appeal	board's decision.)	\$ \$	76,294	6 1 7
7. Real Estate Tax expense reported on Schedule Real Estate Tax History:	Tax Year. (Attach a copy of the V, line 33. This should be a combination of lines 3 thru 6.	real estate tax appeal		\$	76,294	
7. Real Estate Tax expense reported on Schedule	Tax Year. (Attach a copy of the V, line 33. This should be a combination of lines 3 thru 6.	real estate tax appeal	board's decision.) FOR OHF USE ONLY	\$	76,294	
7. Real Estate Tax expense reported on Schedule Real Estate Tax History:	Tax Year. (Attach a copy of the V, line 33. This should be a combination of lines 3 thru 6.	real estate tax appeal		\$ \$ FOR 2004	76,29 ⁴	
7. Real Estate Tax expense reported on Schedule Real Estate Tax History:	Tax Year. (Attach a copy of the V, line 33. This should be a combination of lines 3 thru 6. 2000	13	FOR OHF USE ONLY FROM R. E. TAX STATEMENT F		\$	1
7. Real Estate Tax expense reported on Schedule Real Estate Tax History:	Tax Year. (Attach a copy of the V, line 33. This should be a combination of lines 3 thru 6. 2000 8 2001 9 2002 10		FOR OHF USE ONLY		76,29 ⁴ \$	7
7. Real Estate Tax expense reported on Schedule Real Estate Tax History:	Tax Year. (Attach a copy of the V, line 33. This should be a combination of lines 3 thru 6. 2000	13	FOR OHF USE ONLY FROM R. E. TAX STATEMENT F		\$	1:
7. Real Estate Tax expense reported on Schedule Real Estate Tax History:	Tax Year. (Attach a copy of the V, line 33. This should be a combination of lines 3 thru 6. 2000	13 14	FOR OHF USE ONLY FROM R. E. TAX STATEMENT F PLUS APPEAL COST FROM LIN	NE 5	\$ \$	1 1

NOTES:

- 1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
- 2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please all the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FAC	ILITY NAME Herit	tage Manor-Bloomington		COUNT	Y McLean	
FAC	ILITY IDPH LICENSE 1	NUMBER 0038349				
CON	TACT PERSON REGAI	RDING THIS REPORT				
TEL	EPHONE ()		FAX #: ()		
A.	Summary of Real Esta					
	cost that applies to the o	ber and real estate tax assess peration of the nursing hom vacant, rented to other orga Do not include cost for any p	e in Column D. Real es nizations, or used for pu	state tax applicable rposes other than	e to any portion	of the nursing
	(A)		(B)	(C)		(D)
	Tax Index Numb	<u>er Propert</u>	y Description	Total Ta	<u>1X</u>	Tax Applicable to Nursing Hom
1.	21-04-227-012	Heritage Man	or-Bloomington	\$ 72,503	\$.00	72,503.0
2.				\$	\$	
3.				\$	\$	
4.				\$	\$	
5.				\$		
6.				\$	\$	
7.				\$		
8.				\$	\$	
9.				\$	\$	
10.				\$	\$	
			TOTALS	\$ 72,503	8.00 \$	72,503.0
B.	Real Estate Tax Cost A	Allocations				
	Does any portion of the used for nursing home s	tax bill apply to more than of ervices?			perty which is	not directly
		nation & a schedule which sl e tax cost must be allocated				iome.

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004

C. Tax Bills

tax bill which is normally paid during 2005.

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					STATE OF ILLIN				Page 11
	lity Name & ID Number Heritage UILDING AND GENERAL INFO				#00383	49 Report I	Period Beginning:	01/01/05 Ending:	12/31/05
А.		,183	B. General Construction Type:	Exterior	Wood/Brick	Frame	Wood	Number of Stories	1
C.	Does the Operating Entity?		(a) Own the Facility		a Related Organiza			(c) Rent from Completely U Organization.	nrelated
	(Facilities checking (a) or (b) mu	st compl	ete Schedule XI. Those checking (c)	may complete Sched	ule XI or Schedule X	XII-A. See inst	ructions.)		
D.	Does the Operating Entity?	XX	(a) Own the Equipment	(b) Rent equi	pment from a Relate	ed Organizatio	n.	(c) Rent equipment from Co Unrelated Organization.	
	(Facilities checking (a) or (b) mu	st compl	ete Schedule XI-C. Those checking	(c) may complete Sch	edule XI-C or Sched	lule XII-B. See	instructions.)		
Е.	(such as, but not limited to, apar	tments, a	his operating entity or related to the ssisted living facilities, day training footage, and number of beds/units	g facilities, day care, ir	ndependent living fa				
F.	Does this cost report reflect any If so, please complete the following		tion or pre-operating costs which a	re being amortized?			YES	xx NO	
1.	. Total Amount Incurred:				2. Number of Year	rs Over Which	it is Being Amor	tized:	
3.	. Current Period Amortization:				4. Dates Incurred:	:			
		Na	ture of Costs:						
			(Attach a complete schedule deta	iling the total amount	t of organization and	l pre-operatin	g costs.)		
XI. C	OWNERSHIP COSTS:								
			1	2	3		4		
	A. Land.		Use	Square Feet	Year Acquir	ed e	Cost 116 576	1	
		$\frac{1}{2}$				D	116,576		
		3	TOTALS			\$	116,576	3	

Page 12 12/31/05 Facility Name & ID Number Heritage Manor-Bloomington 0038349 **Report Period Beginning:** 01/01/05 Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	ing Depreciation-including Fixed Equ	2	3	4	5	6	7	8	9	T
	_	FOR BHF USE ONLY	Year	Year		Current Book	Life	Straight Line	-	Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4	111				\$ 560,548	\$		\$	\$	\$	4
5					221,147						5
6											6
7											7
8											8
	Impre	ovement Type**									
9	1978 Improve	ements		1978	14,607			Ι			9
10	1979 Improve	ements		1979	95,460						10
	1980 Improve			1980	75,591						11
	1981 Improve			1981	11,544						12
	1982 Improve			1982	9,256						13
	1983 Improve			1983	13,130						14
	1984 Improve			1984	7,215						15
	1985 Improve			1985	45,885						16
	1986 Improve			1986	13,469						17
	1988 Improve			1988	83,109						18
	1989 Improve			1989	2,439						19
	1990 Improve			1990	30,676						20
	1991 Improve			1991	4,207						21
	1992 Improve			1992	1,208						22
	1993 Improve			1993	97,303						23
24	1994 Improve	ements		1994	29,638						24
25	1995 Improve BOILER	ements		1995	121,304						25
	EXHAUST H	TOOD.		1996 1996	17,850 1,075						26
	CODE ALER			1996	1,075						27 28
	PHONE SYS			1996	2,339						29
	INTERIOR F			1996	103,103						30
31	HILKIOK	TEMODEL		1990	103,103						31
32											32
33											33
	C/O Allocatio	on						13,149	13,149		34
	Book Depreci					123,401		123,401	10,117	1,202,770	35
36	_ : : : : : : : : : : : : : : : : : : :					120,101		,			36
50					1	I		I			50

^{*}Total beds on this schedule must agree with page 2.

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12A 12/31/05 Facility Name & ID Number Heritage Manor-Bloomington 0038349 **Report Period Beginning:** 01/01/05 Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

Improvement Type** Constructed Cost Depreciation in Years Depreciation Adjustments Depreciation		1	3	4	5	6	7	8	9	T
37 Interior Rehab-paint, wallpaper, remodel facility 197 211,945 8 8 8 8 8 8 8 8 8			Year			Life	Straight Line			
38 Remodel Physical Therapy			Constructed		Depreciation	in Years	Depreciation	Adjustments	Depreciation	
39 Disposal Unit-Kitchen 1997 1,439			1997	\$	\$		\$	\$	\$	37
1997 1,998 1,313 1,997 1,997 1,998 1,313 1,314										
1 1 1 1 1 1 1 1 1 1			1997							39
1	40	Code Alert System	1997	1,997						40
43 Code Alert/Nurse Call System 1998 3,55.4	41	Kitchen Remodel	1997	766						
44 Kitchen Remode 1998										
Semodel Physical Therapy										
46 Addition-Materials 1998 13,431 46 47 Addition-Professional Fees 1998 11,381 46 48 47 Addition-Professional Fees 48 50 Addition-Professional Fees 1999 2,2035 50 51 Steam Table Hood 1999 3,821 50 51 52 ALTA Survey 1999 2,434 51 52 53 Dish Washing Area 1999 4,083 52 52 55 Parking Loft Pavement 1999 4,083 53 54 56 Parking Loft Pavement 1999 6,743 55 54 57 Dayroon Light Fixtures 2000 6,189 57 58 57 58 56 57 58 57 58 56 57 58 57 58 57 58 56 57 58 56 57 58 56 57 58 56 57 58 56 57 57 58 56 57 58 56 57 58 57 58 57 58 57 58 5	44	Kitchen Remodel								
AdditionProfessional Fees 1998 109,885	45	Remodel Physical Therapy								
R										
49 Addition—Materials 1999 1,155,066		AdditionProfessional Fees	1998	109,885						
Middition-Professional Fees 1999 22,035 50 50 50 51 51 52 ALTA Survey 51 5199 2,434 52 ALTA Survey 51999 2,434 52 ALTA Survey 51999 2,434 52 ALTA Survey 51999 2,434 53 54 54 54 54 54 54										
51 Steam Table Hood 1999 3,821 51 52 ALTA Survey 1999 2,434 52 31 Dish Washing Area 1999 4,083 53 54 Sewage Pump 1999 2,492 54 55 Parking Lot Pavement 1999 6,743 54 56 56 56 56 57 Dayroom Light Fixtures 56 56 58 Door Kickplates 2000 2,991 58 59 Storn windows 2000 4,011 59 60 AdditionMaterials 2000 12,770 60 61 AdditionProfessional Fees 2000 5,893 61 62 Roof Repair 2000 5,510 62 63 63 64 64 64 64 65 66 66 66 67 67 68 69 69 69 69										
52 ALTA Survey 1999 2,434 52 53 Dish Washing Area 1999 4,083 53 4 Sewage Pump 1999 2,492 54 55 Parking Lot Pavement 1999 6,743 55 56 55 56 56 57 Dayroom Light Fixtures 2000 6,189 56 58 Door Kickplates 2000 2,991 57 59 Storm windows 2000 4,011 59 60 AdditionMaterials 2000 12,770 60 60 61 AdditionProfessional Fees 2000 5,893 61 62 63 Call 60 62 63 62 63 64 Call 64 64 64 64 64 64 64 64 64 64 66 66 66 67 67 68 68 69 68 68 69 68 68 69 68 69 68 68 68 68 69 68 68 69 69 69 69 69 60 6										
S3 Dish Washing Area 1999 4,083 53 54 54 54 55 55 55 5										
54 Sewage Pump 1999 2,492 54 55 Parking Lot Pavement 1999 6,743 55 56 55 55 57 Dayroom Light Fixtures 2000 6,189 57 58 Door Kickplates 2000 2,991 58 59 Storm windows 2000 4,011 59 61 AdditionMaterials 2000 12,770 60 61 AdditionProfessional Fees 2000 5,893 61 62 Roof Repair 2000 5,510 62 63 44 4 4 4 64 4 4 4 4 65 5 5,510 62 66 66 66 66 66 67 6 6 6 6 68 69 6 6 6										
55 Parking Lot Pavement 1999 6,743 55 56 56 56 57 58 59 59 59 59 59 59 59										
56 Dayroom Light Fixtures 2000 6,189 56 57 Door Kickplates 2000 2,991 57 58 Door Kickplates 2000 2,991 58 60 Addition-Materials 2000 4,011 58 61 AdditionProfessional Fees 2000 5,893 61 62 Roof Repair 2000 5,510 62 63 3 56 64 64 4 55 56 65 66 65 65 66 66 66 67 67 67 67 68 69 69 69										
57 Dayroom Light Fixtures 2000 6,189 57 58 Door Kickplates 2000 2,991 58 59 Storm windows 2000 4,011 59 60 AdditionMaterials 2000 12,770 50 60 61 AdditionProfessional Fees 2000 5,893 50 61 61 61 62 62 63 63 64 64 64 64 64 64 64 64 64 64 64 65 65 65 65 65 65 65 65 66 66 66 66 66 66 66 66 66 66 67 67 67 67 67 67 68 68 69 69 69 69 69 69 69 69 69 69 69 69 69 69 60 60 60 60 60 60 69 69		Parking Lot Pavement	1999	6,743						
58 Door Kickplates 2,991 58 59 Storm windows 2000 4,011 59 60 AdditionMaterials 2000 12,770 50 60 61 AdditionProfessional Fees 2000 5,893 50 61 61 62 Roof Repair 2000 5,510 50 63 63 63 63 64 64 64 64 64 64 64 64 64 64 64 65 65 65 65 65 65 66 66 66 66 66 66 66 67 67 67 67 67 67 67 67 67 68 69 69 69 69 69 69 69 69 69 69 69 69 69 69 69 60 60 60 60 60 60 60 60 60 60 60 60 60			2000	. 100						
59 Storm windows 2000 4,011 59 60 AdditionMaterials 2000 12,770 60 61 AdditionProfessional Fees 2000 5,893 61 62 Roof Repair 2000 5,510 62 63	57	Dayroom Light Fixtures		/						
60 AdditionMaterials 2000 12,770 60 60 61 AdditionProfessional Fees 2000 5,893 61 61 62 Roof Repair 2000 5,510 62 63 64 64 64 64 64 64 65 66 66 66 66 66 66 66 66 66 66 66 66 67 68 68 69 68 69 69 69 69 69 69 69 69 69 69 60	58	Door Kickplates								
61 AdditionProfessional Fees 2000 5,893 61 62 Roof Repair 2000 5,510 62 63 63 63 63 64 65 64 65 65 66 66 66 67 68 69 68										
62 Roof Repair 2000 5,510 62 63 63 63 63 64 65 65 65 66 67 68 67 68 69 69 69										
63 64 65 65 66 66 67 68 69 69	-									
64 65 65 66 67 67 68 68 69 69		Root Repair	2000	5,510						
65 65 66 66 67 67 68 68 69 69										
66 66 67 68 69 69										
67 68 69										
68 68 69 69										
69										
70 1111 AT (mag 4 fam) 69)		TOTAL (lines 4 thru 69)		\$ 3,190,158	\$ 123,401		\$ 136,550	\$ 13,149	\$ 1,202,770	70

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12B 12/31/05 STATE OF ILLINOIS ility Name & ID Number Heritage Manor-Bloomington # 003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. Facility Name & ID Number 0038349 **Report Period Beginning:** 01/01/05 Ending:

1	3	4	5	6	7	8	9	Т
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 3,190,158	\$ 123,401		\$ 136,550	\$ 13,149	\$ 1,202,770	1
2 Paging System	2001	2,456						2
3 Alarm Door/Lock	2001	1,950						3
4 Code Alert	2001	3,965						4
5 Electrical Wiring for A/C Unit	2001	1,805						5
6 Main Water Meter	2001	2,000						6
7 Valves Boiler Unit	2001	1,883						7
8								8
9 Smoke Detectors and Installation	2002	14,551						9
10 Mixing valve	2002	1,862						10
11 Main Corridor Rehab (Wallcovering)	2002	3,885						11
12 Floor Tile	2002	1,280						12
13 Kitchen	2002	957						13
14 Roof Repair	2002	5,283						14
15								15
16 Smoke Detectors and Installation	2003	5,970						16
17 Roof Replacement	2003	111,250						17
18 Sprinklers	2003	31,119						18
19 Parking Lot	2003	3,862						19
20 Ceramic Tile	2003	1,315						20
21 Compressor	2003	3,898						21
22 Wallpaper	2003	857						22
23 Maglock Keypad	2003	2,762						23
24 ANSUL Fire Surpression	2003	1,450						24
25 Fire Escape Remodel	2003	2,003						25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33		4 207 521	100 101		126.550	12.142	1 202 == 2	33
34 TOTAL (lines 1 thru 33)		\$ 3,396,521	\$ 123,401		\$ 136,550	\$ 13,149	\$ 1,202,770	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12C 12/31/05 STATE OF ILLINOIS Facility Name & ID Number Heritage Manor-Bloomington 0038349 **Report Period Beginning:** 01/01/05 Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 3,396,521	\$ 123,401		\$ 136,550	\$ 13,149	\$ 1,202,770	1
2								2
3 Sewage Pump	2004	3,823						3
4 Nurses Station A/C	2004	1,478						4
5 Fire Alarm	2004	2,825						5
6 Sealcoat Parking Lot	2004	1,646						6
7 Storm Windows	2004	645						7
8 Window A/C (8)	2004	6,030						8
9 Ceiling Repairs	2004	4,011						9
10								10
11 Delayed Egress Latches	2005	12,431						11
12 Mixing valve		1,360						12
Paint ceiling		596						13
14 A/C		2,153						14
15 Sidewalk		2,100						15
16								10
17								1' 18
18								19
20								20
21							<u> </u>	2
22								2
23								2.
24								2
25								25
26								20
27							 	2
28							 	28
29								29
30								30
31								3
32								32
33								3.
34 TOTAL (lines 1 thru 33)		\$ 3,435,619	\$ 123,401		\$ 136,550	\$ 13,149	\$ 1,202,770	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

CITE A			TT	T	TAT.	OTO.
STA	.116	OF	ш	L	IN	OI5

		r age 15				
Facility Name & ID Number	Heritage Manor-Bloomington	# 0038349	Report Period Beginning	01/01/05	Ending:	12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	7 1 1 1 1 8	Trumsportation (See Instructions)						
	Category of	1	Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Cost	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 1,039,668	\$ 25,904	\$ 25,904	\$		\$ 934,762	71
72	Current Year Purchases	20,547						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,060,215	\$ 25,904	\$ 25,904	\$		\$ 934,762	75

D. Vehicle Depreciation (See instructions.)*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

1

		Reference	Amount			
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	4,612,410	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	149,305	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	162,454	83	*:
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	13,149	84]
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	2,137,532	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

^{*} Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

^{**} This must agree with Schedule V line 30, column 8.

Faci	lity Name & I	D Number	Heritage Manor-Blo	oomington		STATE OF ILLINOIS # 0038349	•	t Period Beginni	ing: 01/01/0	5 Ending:	Page 14 12/31/05
XII.	 Name of Does the 	and Fixed Equip Party Holding L			amount shown below on l]NO				
		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*				
3 4 5	Original Building: Additions				\$			3 B	Effective dates of cu Beginning Ending	irrent rental agree	ement:
6	TOTAL				**			6 11.	Rent to be paid in for rental agreement:	uture years under	the current
	This amo		tization of lease expensed by dividing the total					F 12. 13.	/20 /20	·	ent
	9. Option to B. Equipmer 15. Is Mova	nt-Excluding Tra	YESansportation and Fixed rental included in build	⊐ l Equipment. (§	Ferms:	* YES	√NO	14.	/20	\$	
	16. Rental A		able equipment: \$		Description:		le detailing the brea	kdown of moval	ble equipment)		
	1 Use		2 Model Year and Make	N	3 Ionthly Lease Payment	4 Rental Expense for this Period			* If there is an optic		
17 18 19				\$		\$	17 18 19		please provide con schedule.	•	
20 21	TOTAL			\$		\$	20 21	*	* This amount plus expense must agree		

		S	TATE OF ILLIN	NOIS					Page 15
Facility Name & ID Number Heritage Manor-I				# 003	3 8349]	Report Period Beginning:	01/01/05	Ending:	12/31/05
XIII. EXPENSES RELATING TO CERTIFIED NURSE A	AIDE (CNA) TRAINING	PROGRAMS (See	instructions.)						
A. TYPE OF TRAINING PROGRAM (If CNAs are t	rained in another facility	y program, attach a	schedule listing	the facility nan	ne, address	and cost per CNA trained in	that facility.)		
1. HAVE YOU TRAINED CNAS DURING THIS REPORT	YES 2	CLASSROOM	PORTION:			3. CLINICAL PO	RTION:	_	
PERIOD?	NO	IN-HOUSE PR	OGRAM			IN-HOUSE PRO	OGRAM		
If "yes", please complete the remainder		IN OTHER FA	CILITY			IN OTHER FA	CILITY		
of this schedule. If "no", provide an explanation as to why this training was		COMMUNITY	COLLEGE			HOURS PER C	NA		
not necessary.		HOURS PER C	CNA						
B. EXPENSES	ALLOCATI	ON OF COSTS	(d)			C. CONTRACTUAL IN	ICOME		
	112200111	01, 01 00010	(-)			In the box below	v record the a	mount of in	come vour
	1	2	3		4	facility received			
		cility				To.		7	
1 C	Drop-outs	Completed	Contract	Tot	tai	\$			
1 Community College Tuition	1.70	120	139	130					

		Fa	cility		
		Drop-outs	Completed	Contract	Total
	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		(2,550)		(2,550)
3	Classroom Wages (a)		10,744		10,744
	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 8,194	\$	\$ 8,194
10	SUM OF line 9, col. 1 and 2 (e)	\$ 8,194			

D. NUN	IBER OF CNAs TRAINED	
	COMPLETED	
	1. From this facility	
	2. From other facilities (f)	
	DROP-OUTS	
	1. From this facility	
	2. From other facilities (f)	
	TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8			
		Schedule V	Staf	f	Outsid	Outside Practitioner		Outside Practitioner Su				
	Service	Line & Column	Units of	Cost	(other th	nan consultant)	(Actual or)	Total Units	Total Cost			
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. $3 + 5 + 6$)			
1	Licensed Occupational Therapist		hrs	\$		\$ 233,978	\$		\$ 233,978	1		
	Licensed Speech and Language											
2	Development Therapist		hrs			23,554			23,554	2		
3	Licensed Recreational Therapist		hrs							3		
4	Licensed Physical Therapist		hrs			321,145	709		321,854	4		
5	Physician Care		visits							5		
6	Dental Care		visits							6		
7	Work Related Program		hrs							7		
8	Habilitation		hrs							8		
			# of							T		
9	Pharmacy		prescrpts				466,692		466,692	9		
	Psychological Services											
	(Evaluation and Diagnosis/											
10	Behavior Modification)		hrs							10		
11	Academic Education		hrs							11		
12	Exceptional Care Program									12		
										T		
13	Other (specify):					40,878			40,878	13		
14	TOTAL			\$		\$ 619,555	\$ 467,401		\$ 1,086,956	14		

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Page 17 ility Name & ID Number Heritage Manor-Bloomington

XV. BALANCE SHEET - Unrestricted Operating Fund. Facility Name & ID Number 0038349 **Report Period Beginning:** 01/01/05 12/31/05 **Ending:**

As of 12/31/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1		2 After	
		0	perating	Consolidation*	
	A. Current Assets			1.	
1	Cash on Hand and in Banks	\$	400	\$	1
2	Cash-Patient Deposits		9,492		2
	Accounts & Short-Term Notes Receivable-				
3	Patients (less allowance)		734,975		3
4	Supply Inventory (priced at)				4
5	Short-Term Investments				5
6	Prepaid Insurance		18,612		6
7	Other Prepaid Expenses				7
8	Accounts Receivable (owners or related parties)		599,293		8
9	Other(specify):				9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	1,362,772	\$	10
	B. Long-Term Assets				
11	Long-Term Notes Receivable				11
12	Long-Term Investments				12
13	Land		116,576		13
14	Buildings, at Historical Cost		3,377,700		14
15	Leasehold Improvements, at Historical Cost				15
16	Equipment, at Historical Cost		1,028,594		16
17	Accumulated Depreciation (book methods)		(2,137,532)		17
18	Deferred Charges				18
19	Organization & Pre-Operating Costs				19
	Accumulated Amortization -				
20	Organization & Pre-Operating Costs				20
21	Restricted Funds				21
22	Other Long-Term Assets (specify):				22
23	Other(specify):				23
	TOTAL Long-Term Assets				
24	(sum of lines 11 thru 23)	\$	2,385,338	\$	24
	TOTAL ASSETS				
25	(sum of lines 10 and 24)	\$	3,748,110	\$	25

		1 0	perating	2 After Consolidation*	
	C. Current Liabilities				
26	Accounts Payable	\$	96,048	\$	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits		9,492		28
29	Short-Term Notes Payable				29
30	Accrued Salaries Payable		237,703		30
	Accrued Taxes Payable				
31	(excluding real estate taxes)		3,028		31
32	Accrued Real Estate Taxes(Sch.IX-B)		76,128		32
33	Accrued Interest Payable		7,975		33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
36					36
37					37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	430,374	\$	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable				39
40	Mortgage Payable		1,794,557		40
41	Bonds Payable				41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify):				•
43					43
44					44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$	1,794,557	\$	45
	TOTAL LIABILITIES				
46	(sum of lines 38 and 45)	\$	2,224,931	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$	1,523,179	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$	3,748,110	\$	48

^{*(}See instructions.)

Facility Name & ID Number Heritage Manor-Bloomington
XVI. STATEMENT OF CHANGES IN EQUITY

	IANGES IN EQUITY	1	1	Т	1
			Total		
1	Balance at Beginning of Year, as Previously Reported	\$	1,428,858	1	1
2	Restatements (describe):			2	1
3				3	1
4				4	1
5				5	
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	1,428,858	6	
	A. Additions (deductions):				
7	NET Income (Loss) (from page 19, line 43)		94,321	7	
8	Aquisitions of Pooled Companies			8	
9	Proceeds from Sale of Stock			9	
10	Stock Options Exercised			10	
11	Contributions and Grants			11	
12	Expenditures for Specific Purposes			12	
13	Dividends Paid or Other Distributions to Owners	()	13	1
14	Donated Property, Plant, and Equipment			14	
15	Other (describe)			15	
16	Other (describe)			16	
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	94,321	17	
	B. Transfers (Itemize):				
18				18	
19				19	
20				20	
21				21	
22				22]
23	TOTAL Transfers (sum of lines 18-22)	\$		23	
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	1,523,179	24	*

^{*} This must agree with page 17, line 47.

Report Period Beginning:

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue All Levels of Care	\$ 5,270,354	1
2	Discounts and Allowances for all Levels	(1,690,922)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,579,432	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,424,112	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,424,112	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	383	12
13	Barber and Beauty Care	22,064	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	6,120	16
17	Sale of Drugs	553,749	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	10	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 582,326	23
	D. Non-Operating Revenue		
	Contributions		24
	Interest and Other Investment Income***	158	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 158	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,586,028	30

		2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	910,380	31
32	Health Care	2,959,237	32
33	General Administration	1,249,516	33
	B. Capital Expense		
34	Ownership	354,652	34
	C. Ancillary Expense		
35	Special Cost Centers	15,582	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37		2,340	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,491,707	40
41	Income before Income Taxes (line 30 minus line 40)**	94,321	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 94,321	43

* T	This must	agree with	page 4.	line 45	, column 4.
-----	-----------	------------	---------	---------	-------------

** Does this agree with taxable income (loss) per Federal Income
Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

^{****}Provide a detailed breakdown of "Other Revenue" on an attached sheet.

0038349

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	01	,		
1	2**	k	3	4
	_		•	•

		1	2**	3	4	
		# of Hrs.	# of Hrs.	Reporting Period	Average	
		Actually	Paid and	Total Salaries,	Hourly	
		Worked	Accrued	Wages	Wage	
1	Director of Nursing	1,936	2,267	\$ 51,191	\$ 22.58	1
2	Assistant Director of Nursing	1,380	1,520	29,027	19.10	2
3	Registered Nurses	9,687	10,371	205,706	19.83	3
4	Licensed Practical Nurses	23,540	25,484	491,304	19.28	4
5	CNAs & Orderlies	73,141	76,993	780,170	10.13	5
6	CNA Trainees	1,100	1,100	10,744	9.77	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,248	2,481	34,396	13.86	8
9	Activity Director					9
	Activity Assistants	5,542	5,856	52,473	8.96	10
	Social Service Workers	3,693	4,279	46,862	10.95	11
	Dietician					12
	Food Service Supervisor					13
	Head Cook					14
15	Cook Helpers/Assistants	19,267	21,026	216,875	10.31	15
	Dishwashers					16
17	Maintenance Workers	9,060	9,719	103,236	10.62	17
	Housekeepers	9,895	10,408	76,776	7.38	18
19	Laundry	6,105	6,842	65,324	9.55	19
20	Administrator	1,900	2,080	59,000	28.37	20
	Assistant Administrator					21
	Other Administrative					22
23	Office Manager					23
	Clerical	8,788	9,851	122,705	12.46	24
	Vocational Instruction					25
	Academic Instruction					26
	Medical Director					27
	Qualified MR Prof. (QMRP)					28
	Resident Services Coordinator					29
	Habilitation Aides (DD Homes)					30
31	Medical Records					31
	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	177,282	190,277	\$ 2,345,789 *	\$ 12.33	34

^{*} This total must agree with page 4, column 1, line 45.

B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		12,000		36
37	Medical Records Consultant		1,800		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,982		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		2,509		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 19,291		49

C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses	148	\$ 4,432		50
51	Licensed Practical Nurses	2,122	53,057		51
52	Certified Nurse Assistants/Aides	2,737	54,735		52
53	TOTAL (lines 50 - 52)	5,007	\$ 112,224		53

^{**} See instructions.

STATE OF ILLINOIS			Page	21
# 0038349	Report Period Beginning:	01/01/05	Ending:	12/31/05

XIX. SUPPORT SCHEDULES	_									
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	%	Amount	Description		Amount	Description	Amount		
Julie Cadle admin \$ 59,000		59,000	Workers' Compensation Insurance \$ 51			IDPH License Fee	\$			
			Unemployment Compensation Insurance		34,290	Advertising: Employee Recruitment	10,68			
		FICA Taxes	179,453	Health Care Worker Background Check						
				Employee Health Insurance		174,059	(Indicate # of checks performed)	1,75		
		<u> </u>		Employee Meals			Central Office Allocation	4,71		
		<u> </u>		Illinois Municipal Retirement Fund (IMRF)*			Promotional Advertising	9,58		
				Employee Hepatitis Vaccine		0	Public Relations	10,69		
TOTAL (agree to Schedule V, line	17, col. 1)			Employee Benefits -	_	13,850	Dues and Subscriptions	7,02		
(List each licensed administrator separately.) \$ 59,000			Employee Benefits - central office 40,355			License and Fees	6,68			
B. Administrative - Other	<u> </u>				_					
							Less: Public Relations Expense	(10,69		
Description A		Amount				Non-allowable advertising	(52			
F. 1. 2		\$					Yellow page advertising	(9,58		
							Frigo war variable	(-)		
-				TOTAL (agree to Schedule V,	\$	493,303	TOTAL (agree to Sch. V,	\$ 30,32		
				line 22, col.8)		., .,	line 20, col. 8)			
TOTAL (agree to Schedule V, line	17, col. 3)			E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**			
(Attach a copy of any management		nt)		to Owners or Employees						
C. Professional Services	service agreemen	10)		to owners of Employees			Description	Amount		
Vendor/Payee	Type		Amount	Description Line #		Amount	Description	imount		
Heritage Enterprises	Mgt Fee	•	338,228	Description Line #	•	Amount	Out-of-State Travel	•		
Heritage Enterprises	Nigi Fee	Ψ	0		Ψ_		Out-or-State Travel	Ψ		
			0							
							In-State Travel			
		<u> </u>					In-State Travei	1.22		
								1,23		
					_			1		
							Seminar Expense	3,09		
					_			(12,67		
			0		_			10,33		
Legal Adjusted to Zero			4,935		_					
			0				Entertainment Expense	(
TOTAL (agree to Schedule V, line				TOTAL	\$_		(agree to Sch. V,			
(If total legal fees exceed \$2500 atta	ch copy of invoic	es.) \$	343,163		_		TOTAL line 24, col. 8)	\$ 1,99		

Facility Name & ID Number

Heritage Manor-Bloomington

^{*} Attach copy of IMRF notifications

^{**}See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3). (See instructions.)

Facility Name & ID Number Heritage Manor-Bloomington

1 3 5 6 7 8 9 10 11 12 13 **Amount of Expense Amortized Per Year** Month & Year **Improvement Improvement Total Cost** Useful Type Was Made Life FY2002 FY2003 FY2004 FY2005 FY2006 FY2007 FY2008 FY2009 FY2010 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 \$ **TOTALS**

			OF ILLINOIS	D (D 1 ID 1 1	04/04/05	F 11	Page 23
	y Name & ID Number Heritage Manor-Bloomington	#	0038349	Report Period Beginning:	01/01/05	Ending:	12/31/05
	ENERAL INFORMATION:	(12)	II		. 4 41 4	1. 1.91. 14.	
(1)	Are nursing employees (RN,LPN,NA) represented by a union? no	(13)		supplies and services which are of the			
(2)	And there are dues to numing home associations included on the cost remark?			addition to the daily rate, been propertion of Schedule V? yes	eriy ciassified		
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount. Illinois Healthcare Association		in the Ancillary Se	ection of Schedule V? yes	_		
	11 YES, give association name and amount. Ininois Healthcare Association	(14)	Is a moution of the	huilding used for any function other	than lang tame		for
(3)	Did the nursing home make political contributions or payments to a political	(14)		building used for any function other listed on page 2, Section B? yes	man long term	For example	
(3)	action organization? yes If YES, have these costs			building used for rental, a pharmacy,	day agra eta		
				explains how all related costs were al			лі
	been properly adjusted out of the cost report? yes		a schedule which e	explains now all related costs were at	located to thes	e functions.	
(4)	Does the bed capacity of the building differ from the number of beds licensed at the	(15)	Indicate the cost of	f employee meals that has been recla	ssified to emp	lovee benefits	
(4)	end of the fiscal year? no If YES, what is the capacity?	(15)	on Schedule V.			been offset ag	ainst
	in 125, what is the capacity.		related costs?		the amount.		
(5)	Have you properly capitalized all major repairs and equipment purchases? yes		related costs.	mindreate	the uniount.	720	
(0)	What was the average life used for new equipment added during this period? 7 years	(16)	Travel and Transpo	ortation			
	your was are average me used for new equipment added daring and period?	(20)		ncluded for out-of-state travel?	no		
(6)	Indicate the total amount of both disposable and non-disposable diaper expense			complete explanation.			
	and the location of this expense on Sch. V. \$ 5,000 Line 10			eparate contract with the Department	to provide m	edical transpor	tation for
	<u> </u>		residents? no				
(7)	Have all costs reported on this form been determined using accounting procedures		program during	this reporting period. \$			
	consistent with prior reports? yes If NO, attach a complete explanation.		c. What percent of	all travel expense relates to transpor	tation of nurse	s and patients	? 100%
				age logs been maintained? yes			
(8)	Are you presently operating under a sale and leaseback arrangement? no		e. Are all vehicles	stored at the nursing home during the	e night and all	other	
	If YES, give effective date of lease.		times when not				
				commuting or other personal use of a	ıutos been adjı	usted	
(9)	Are you presently operating under a sublease agreement? YESXXNO)	out of the cost re	eport? yes			
			g. Does the facili	ity transport residents to and fr	om day trair	ning?	no
(10)	Was this home previously operated by a related party (as is defined in the instructions for			mount of income earned from p	roviding suc	2h	
	Schedule VII)? YES NO xx If YES, please indicate name of the facility	' ,	transportation	n during this reporting period.		\$	_
	IDPH license number of this related party and the date the present owners took over.	(15)	TT 12.1		1 1.12		
		(17)		performed by an independent certificulaski & Webb	a public accor	unung mm? The instruct	yes
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department			that a copy of this audit be included	with the cost t		
(11)	during this cost report period. \$ 60,773			No If no, please explain.	Not availab		s copy
	This amount is to be recorded on line 42 of Schedule V.		been attached:	ii no, picase explain.	10t availab	IC	
	This amount is to be recorded on time 42 of Benedule V.	(18)	Have all costs which	ch do not relate to the provision of lo	ng term care l	neen adjusted (aut
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V	(10)	out of Schedule V		ng term care e	reen aajastea (,
(12)	for an individual employee? no If YES, attach an explanation of the allocation.		and a solitoria v	<u>, , , , , , , , , , , , , , , , , , , </u>			
		(19)	If total legal fees a	re in excess of \$2500, have legal inv	oices and a sur	mmary of serv	rices
		(=>)		cached to this cost report? yes		J == 5 01 (
				d a summary of services for all archi	tect and appra	isal fees.	

BASIC CHARGE-DA BASIC CHARGE-MEDICANE	ME 0	
BASE CHARGE-MEDICARE DAY CARESIOME CARE LIGHT NURSING CARE	-93,001	
MEDIUM NURSING CARE HEAVY NURSING CARE SKILLED NURSING CARE		
NURSING SUPPLIES-PRIVATE NURSING SUPPLIES-IPA	-298,064	
NURSING SUPPLIES MED PT A NURSING SUPPLIES MED PT B DRUGS	-553,749	
DRUGS-OTHER PT-PRIVATE	1,424,112	
PT-IPA PT-MEDICARE PART A		
PUBLIC AID ASSESSMENT INC LABORATORY INCOME		
SPEECHOT-PRIVATE SPEECHOT-IPA		
SPEECH OT MED PART A SPEECH OT MED PART B	1 000 000	
MEDICAED PART B DISCOUNT MEDICARE DISCOUNTS	.,	
ASSESSMENT TAX EXPENSE RENT INCOME	-6,120	
ACTIVITY SHOP ACTIVITY PUND INCOME VENDING INCOME EXPENSE	-22,064 0 -383	
MANAGEMENT FEES EQUIPMENT RENTAL	-13,582	
RESIDENT TRANSPORTATION MESC INCOME GENERAL & ADMINIST WAGES	-00	122.205
ADMINISTRATOR WAGES VACATION & SICK - GRA	59,000 8,134	122,705 59,000 452,948
EMPLOYEE BENEFITS EMPLOYEE REPETITES VACCING	13,850	452,948
EMPLOYEE SCHOLORSHIP COST DIRECTORS FEES		
OFFICE SUPPLIES TELEPHONE	13,838 15,148	15,067 15,148 692 4,337
GENERAL TRAVEL MEAL EXPENSE FOR TRAVEL	1,233	4,337
EDUCATION & SEMINAR HELP WANTED ADVERTISING	3,092 10,680	107,192
PROMOTIONAL ADVERTISING PUBLIC RELATIONS	9,582 10,688	
DUES & SUBSCRIPTIONS CONTRIBUTIONS	7,022	
PROFESSIONAL FEES MEDICAL DIRECTOR	4,935 12,000	343,163 12,000
OTHER PHYSICIAN FIES MEDICAL RECORDS CONSULT	1,800	
PRIARMACIST FEES SOC SERVIACT CONSULT	2,992 2,509	2,509
TV RENTAL INCOME TAXES BACKGROUND CHECKS	1,217	51,096
PAYROLL TAXES PAYROLL TAXES ADMINIST	207,609 6,124	
GROUP INSURANCE LIABILITY INSURANCE	174,099 78,148	78,148
WORKMENS COMP INSURANCE CENTRAL OFFICE FEES	51,296 338,228	
BAD DEBTS LOST ITEMS-RESIDENTS	51,000 96	
MISCELLANEOUS REAL ESTATE TAXES LEASED EQUIPMENT	76,294	76,294
MAINTENANCE SALARIES MAINTENANCE SICK & VAC	97,330 5,906	76,294 3,699 103,236 121,097
RESCURED NATURAL GAS	49,290 48,835	121,097
WATER & SEWER TRASH COLLECTION	22,972 8,036	41,339
PROPERTY PLANT REPLACEMN GENERAL REPAIR & MAINT	17,872 35,700	41,339 53,572
MAINTENANCE CONTRACTS DETARY WAGES DETARY SET & VAC	33,388 204,835 17,040	216,875
SALES TAX FOOD PURCHASES	176,583	175,860 24,905
SUPPLES DESIWASSING DISTARY REPLACEMENT	3,162	24,905
MEAL CREDIT LAUNDRY WAGES	-723 60,940	65,724
LAUNDRY SICK & VAC LAUNDRY REPLACEMENT	4,784 8,779	14,599
LAUNDRY REIMBURSEMENT LAUNDRY SUPPLIES BOUSEKEEPING WASTEN	6,220 72,623 4,153 6,384 10,413 191,607 51,191 29,027 14,099 0 462,707	65,324 14,599 76,776 16,797
HOUSEKEEPING SICK & VAC HOUSEKEEPING SUPPLIES	4,153 6,384	16,797
ROUSEKEEPING SUPPLIES PPR RN WAGES-MEDICARE RN WAGES-NON-MEDICARE	10,413	1,591,794
DON WAGES ADON	51,191 29,027	
RN SICK & VACATION LPN WAGES-MEDICARE	14,099	
LIPN WAGES OTHER LIPN SECK & VACATION	28,597	
AIDE WAGES-MEDICARE AIDE WAGES-NON MEDICARE	714,626	
WARD CLERKS AUDE VACATION & SICK CONTRACT NURSES AN	65,544	
CONTRACT NURSES-LPN CONTRACT NURSES-AERS	53,057 54,735	
NURSE AIDE TRAINING WAGES NURSE AID TRAINING EXP	10,744 -2,550	10,744 -2,550
REHAB WAGES REHAB SICK & VAC	31,519 2,877	
NURSING DEPT EDUCATION NURSING SUPPLIES	128,457	145,257
NURSING SUPPLIES REPLACEMENT NURSING NURSING OTHER	6,663 10,137 g 600	12504
DRUG PURCHASES DRUG PURCHASES-OTHER	205,031 147,477	125,045 353,217 619,555
LABORATORY SERVICES HOME HEALTH SALARY	40,878	619,555
HOME HEALTH EXPENSES ACTIVITIES WAGES	49,347	52,473
ACTIVITIES SICK & VAC ACTIVITIES SUPPLIES	3,126 2,299	52,473 2,259 0
ACTIVITIES FEES PT WAGES PT SICK & VACATION	0	•
PT FEES PT SUPPLIES	321,145 709	
SOCIAL SERVICE WAGES SOCIAL SERVICE SICK & VAC	45,807 1,055	46,862
OT HE SOCIAL THERAPIST HE	233,978 0	92
SPEECH THERAPY FEE BEAUTICIAN WAGES	23,554	
BEAUTICIAN SICK & VAC	15,582 0	15,582
DEALERS CHOOLESTERS INC.	0	•
BEAUTY SHOP SUPPLIES VOLUNTEER COORDINATOR VOL COORD SICK & VAC	1,249	
BEAUTY SHOP SUPPLIES VOLUNTEER COGEDINATOR VOL COORD SICK & VAC VOL COORD SUPPLIES RENT		
BEAUTY SHOP SUPPLIES VOLUNTEER COGRENATOR VOL COORD SICK & VAC VOL COORD SICK A VAC VOL COORD SICK BEAUTY ENT ENT ENT ENT ENT ENTEREST EXPENSE DEPRECIATION LOAN FEE AMORTIZATION	119,880 149,385 5,534	149,305
BEAUTY SHOP SUPPLIES VOLNOTIER CORRENATOR VOL COORD SUPPLIES RINT INTEREST EXPESSE BEFFEETINN LOAN FEE AMORTIZATION INTEREST INCOME MISS NON-OPERATING INCOME MISS NON-OPERATING INCOME	119,880 149,385 5,534 -158 0	149,305
AND COMMENT TO AND CO	1,349 119,880 149,385 5,534 -158 0 2,340 5,401,549 -94,321 SET INCOR	149,305

					2,612	111	3,471,750	71,391,262	
Name	Title	Function	Total Pay	usted by Mgmt Fe	Total # Beds	Facility # Beds	Jon-Nursing Hom	Nursing Home	This Facility
### Susie Jefferson	Director	Management	418,245	418,245			19,396	398,849	16,950
### Tom Jefferson	Secretary	Management	0	0			0	0	0
### Craig Hart	Chairman	Management	469,049	469,049			21,752	447,297	19,008
### Cheryl Lowney	Executive Vice Presic	Management	279,290	279,290			12,952	266,338	11,318
### Steve Wannemache	President	Management	363,969	363,969			16,879	347,090	14,750
### Connie Hoselton	Sr Vice President	Management	179,584	179,584			8,328	171,256	7,278
### Craig Ater	Sr Vice President	Management	201,279	201,279			9,334	191,945	8,157
Ben Hart			79,758	79,758			3,699	76,059	3,232
13			1,991,174	1,991,174				1,898,834	80,693

^{*} If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the homes(s) as well as the amount paid. This amount must agre 0 5,571,251 total salaries 1,991,174

^{**}This must include all forms of compensation paid by related entities and allocated to Schedule V o 0 total mgt fees
PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND
MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.